

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1700

## CERTIFICATE OF DEATH

Reg. Dist. No. 12412 190

## 1. PLACE OF DEATH:

County HOWARDCity or town ELK RIDGE  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State ENGLAND CountyCity or town LIVERPOOL  
(If outside city or town limits, write RURAL and give nearest town)Street No. 22 REGINA ROAD  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

HARRY BIRKETT

## 3. (b) Social Security Number

none

## 4. Sex

m

## 5. Color or race

w

## 6. (a) Single, married, widowed, or divorced

married

## 6. (b) Name of husband or wife

Heaven Birkett

## 7. Birth date of deceased (mo., day, yr.)

Jan. 30, 1898

## 6. (c) If alive, give age..... years

## 8. AGE:

Years

Months

Days

If less than one day

471115

hrs.

min.

## 9. Birthplace

England  
(Town, county, and state)

## 10. Usual occupation

merchant seaman

## 11. Industry or business

FATHER  
MOTHER

## 12. Name

John Birkett

## 13. Birthplace

England

## 14. Maiden name

unknown

## 15. Birthplace

"

## 18. Informant

Mrs. Berta P. Jacobs

## Address

1713 Severing and Elkridge Md

## 17.

Burial  
(Burial, cremation, or removal. Which?)

## Date thereof

Dec 19<sup>th</sup> 1945  
(month) (day) (year)

## Cemetery or crematory

Lorraine

## Location

Balto. Co. Md.

## 18. Funeral director

William Cook Inc

## Address

1217 St. Paul st

## 19.

1/8/48  
(Date rec'd by registrar)

19

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 12/15 19 45, at 11 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

12/15 19 45, to 12/15 19 45and that I last saw him alive on no date 19 45

Immediate cause of death

Fracture of Skull & base

DURATION

instant

Due to

Due to

Other conditions

fracture of pelvisinstant

(Include pregnancy within 3 months of death)

Major findings of operations

none

Date of op.

Autopsy results

none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide accident Date of 12/15/45Where did injury occur? Elkridge Howard Md.  
(City or town) (County) (State)Injured at home, farm, industry, public place (where?) Belts Washington Blvd.Means of injury struck by auto Injured at work? no

23. SIGNATURE

George E. Bengtson MD  
DEPUTY MEDICAL EXAMINER OF HOWARD COUNTY M. D. or otherAddress Elkridge City Md Date signed 12/15/45

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## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (742)

## CERTIFICATE OF DEATH

12413  
★ Reg. Dist. No. 193

## 1. PLACE OF DEATH:

County Howard Co.City or town Burien near Florence  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 6 1/2 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County HowardCity or town Florence near Woodbine  
(If outside city or town limits, write RURAL and give nearest town)Street No. East near Florence & Woodbine  
(If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (a) FULL NAME

Walter Sullivan Black

## 3. (b) Social Security Number

None

4. Sex

M.

5. Color or race

W.

6. (a) Single, married, widowed, or divorced

married

6. (b) Name of husband or wife

Mathematic Warfield Jones

7. Birth date of deceased (mo., day, yr.)

Oct. 4 18638. (c) If alive, give age 82 years

8. AGE:

Years

Months

Days

If less than one day

8220

hrs.

min.

9. Birthplace

Baltimore City, Md.  
(Town, county, and state)

10. Usual occupation

farmer

11. Industry or business

FATHER

12. Name

Samuel W. Black

13. Birthplace

Baltimore City, Md.

MOTHER

14. Maiden name

Margaret Black

15. Birthplace

Baltimore, Md.

18. Informant

Mr. J. Hubert Black

Address

Woodbine Carroll Co. Md.

17.

Burial  
(Burial, cremation, or removal. Which?)

Date thereof

12/6/45  
(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

C. M. Walth

Address

Westminster, Md.

19.

Dec. 5  
(Date rec'd by registrar)

19. 45

A. W. Hedrich  
Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH

December 4 1945 at 9:30 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Sept Oct 11 1945 to Dec 4 1945  
and that I last saw him alive on Dec 3 1945

Immediate cause of death

Coronary Thrombosis

DURATION

1 da

Due to

Coronary Arterio sclerosis

6 yrs

Due to

General Arterio-sclerosis

? yrs

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

none

Date of op.

Autopsy results

none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Stanley Grabill

M. D. number

Address

Westminster, Md.

Date signed

12/5/45

RECEIVED

JAN 7 1946

BUREAU V.S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 950

## CERTIFICATE OF DEATH

12414

Reg. Dist. No. 191

### 1. PLACE OF DEATH:

County Howard

City or town Elkridge  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Howard

City or town Elkridge  
(If outside city or town limits, write RURAL and give nearest town)

Street No. Route 4  
(If rural, give LOCATION)

2.(a) If veteran, name war

### 3. (a) FULL NAME

Alexander Brown

### 3. (b) Social Security Number

4. Sex M 5. Color or race C B.(a) Single, married, widowed, or divorced Widower

6.(b) Name of husband or wife Maely Brown

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 14, 1870

8. AGE: Years 75 Months 10 Days 22 If less than one day  
hrs. min.

9. Birthplace Maryland  
(Town, county, and state)

10. Usual occupation None

### 11. Industry or business

FATHER 12. Name William Brown

13. Birthplace md

MOTHER 14. Maiden name Louisa Meddow

15. Birthplace md

16. Informant Mrs. Edward Wynn

Address Elkridge, md.

17. Buried Date thereof 12-9-45  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Stell's

Location Bella me

18. Funeral director F.C. Sigismundson

Address Elkridge City md

19. Dec 9 19 45 John B. Lughan  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH December 6, 1945 at 1 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 5 19 45 to Dec 6 19 45

and that I last saw him alive on Dec 6 19 45

Immediate cause of death Acute Gastric  
and Colic Disease

DURATION 2 days  
2 yrs.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE John B. Lughan M.D.

Address Elkridge Md. Date signed 12-7-45

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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OCT 11 1945  
BUREAU V. 8

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## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 191

## 1. PLACE OF DEATH:

County... Howard  
 City or town... Main Street Ellicott City  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... Howard  
 City or town... Ellicott City  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No... Main Street  
 (If rural, give LOCATION)

2.(a) If veteran, name war...

## 3. (a) FULL NAME

Eleanor Brown

## 3. (b) Social Security Number

None

4. Sex

Female Colored Single

5. Color or race

6.(a) Single, married, widowed, or divorced

6.(b) Name of husband or wife

6.(c) If alive, give age..... years

7. Birth date of

deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

781023

hrs.

min.

9. Birthplace

Howard Co Md  
(Town, county, and state)

10. Usual occupation

Domestic

11. Industry or business

FATHER

12. Name

John Brown

13. Birthplace

Howard Co.

MOTHER

14. Maiden name

Martha Sugar

15. Birthplace

Howard Co Md.

16. Informant

Mrs Alice Stenson

Address

Ellicott City Md.

17.

Burial  
(Burial, cremation, or removal, Which?)

Date thereof

Dec. 13, 1945  
(month) (day) (year)

Cemetery or crematory

Western Star Cem.

Location

Baltimore Co. Md.

18. Funeral director

Easton Sons

Address

Ellicott City, Md.

19.

Dec 13  
(Date rec'd by registrar)

1945

John B. Longman

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH

Dec. 10, 1945, 10:45 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

Jan 23 1939, to Dec. 10 1945  
and that I last saw her alive on Dec. 10 1945

Immediate cause of death

Hypertensive Cardiovascular Disease

DURATION

6 years

Due to

Due to

Other conditions Arthritis2 yr.

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

George E. Bunting, M.D.  
Address Ellicott City, Md. Date signed 12/11/45



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DEC 18 1945  
BUREAU U.S.

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## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

12416

Reg. Dist. No. 190

## 1. PLACE OF DEATH:

County HowardCity or town Elkridge  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 2 yrsHospital, institution, or street address where death occurred:  
Wash Blvd.

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md County HowardCity or town Elkridge  
(If outside city or town limits, write RURAL and give nearest town)Street No. Wash Blvd.  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Susie Sarah Creamer

## 3. (b) Social Security Number

4. Sex Female5. Color or race white6. (a) Single, married, widowed, or divorced Widowed8. (b) Name of husband or wife William F. Creamer8. (c) If alive, give age 7 years7. Birth date of deceased (mo., day, yr.) Oct 11 18948. AGE: Years 91 Months 1 Days 6 If less than one day hrs. min.9. Birthplace Landon Co. Va.  
(Town, county, and state)10. Usual occupation Domestic11. Industry or business Retired12. Name Darryl13. Birthplace Virginia14. Maiden name unknown15. Birthplace "16. Informant Mr. Wm F. CreamerAddress Elkridge 22 md17. Removal 12.17.45  
(Burial, cremation, or removal. Which?) Date thereof (month) (day) (year)Cemetery or crematory Salem Methodist CemeteryLocation Hillsboro - Landon Co. VA.18. Funeral director Edson SonsAddress Elkridge City - md19. Dec 17 1945 (Date rec'd by registrar)20. Signature Miss Bird WilliamsAddress Elkridge md21. Date signed 12/17/45

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 17 1945 at 8 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dec 15 1945 to Dec 17 1945and that I last saw him alive on Dec 16 1945Immediate cause of death Chronic Myocarditis DURATION 6 moDue to Sclerosis 10 yrsDue to General arterio "Other conditions Sclerosis

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE B. B. Williams M. D. or otherAddress Elkridge md Date signed 12/17/45



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RECEIVED

RECEIVED  
DEC 18 1945  
BUREAU V.S.



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## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 32

## CERTIFICATE OF DEATH



Reg. Dist. No.

12417  
195

## 1. PLACE OF DEATH:

County HowardCity or town Gulfport  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death:

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County HowardCity or town Gulfport  
(If outside city or town limits, write RURAL and give nearest town)Street No. Jessup, R. 7, D.  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Louis Francis Cullen

## 3. (b) Social Security Number

4. Sex M. 5. Color or race W. 6.(a) Single, married, widowed, or divorced Married6.(b) Name of husband or wife Eleanor Cullen7. Birth date of deceased (mo., day, yr.) Mar. 19 18858. AGE: Years 09 Months 8 Days 14 It less than one day hrs. min.9. Birthplace Yorkshire Eng.  
(Town, county, and state)10. Usual occupation Manual

11. Industry or business

12. Name John Cullen13. Birthplace England14. Maiden name Matie McPartain15. Birthplace England18. Informant Mr. Eleanor CullenAddress Jessup, Md.17. (Burial, cremation, or removal. Which?) Burial Date thereof Dec 6, 1945  
(month) (day) (year)Cemetery or crematory St. Joseph'sLocation Bladensburg, Md.18. Funeral director Frank ShipleyAddress Jessup, Md.19. 12/6/45 (Date rec'd by registrar) Registrar Frank Shipley

## MEDICAL CERTIFICATION

20. DATE OF DEATH 12-3-45 at 10:00 A. M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 3 1945, to Dec 3 1945and that I last saw him alive on 12-3-45Immediate cause of death Coronary Thrombosis DURATION 1 DayDue to Myocardial Infarction 4 yrs

Due to

Other conditions Obesity

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. M. Mauer M.D. M. D. or otherAddress Laurel Date signed 12/3/45

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DEC 10 1945

BUREAU V.S.

3

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 46B

## CERTIFICATE OF DEATH

12418

Reg. Dist. No. 191

## 1. PLACE OF DEATH:

County HowardCity or town Elliott City  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County HowardCity or town Elliott City  
(If outside city or town limits, write RURAL and give nearest town)Street No. St Johns Lane  
(If rural, give LOCATION)

2(a) If veteran, name war

## 3. (a) FULL NAME

Anna Louise Dronfield

## 3. (b) Social Security Number

none

4. Sex <u>F</u>	5. Color or race <u>W</u>	6. (a) Single, married, widowed, or divorced <u>married</u>
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B. (b) Name of husband or wife Lawrence Dronfield

B. (c) If alive, give age \_\_\_\_\_ years

7. Birth date of decedent (mo., day, yr.) Sept. 15, 1896

8. AGE:	Years	Months	Days	If less than one day
	<u>59</u>	<u>2</u>	<u>22</u>	hrs. min.

9. Birthplace Baltimore, Md.  
(Town, county, and state)10. Usual occupation at home

11. Industry or business

12. Name Wm. D. Thompson13. Birthplace England14. Maiden name Mary Marshall15. Birthplace England16. Informant Lawrence DronfieldAddress Elliott City Md.17. Burial Date thereof Dec. 11, 1945  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory St. John'sLocation Elliott City Md.18. Funeral director J. C. HigginbottomAddress Elliott City Md.19. Dec. 9, 1945 John B. Ingraham  
(Date rec'd by registrar) (month) (day) (year) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 7, 1945 at 10 P. M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 16, 1945 to Dec. 7, 1945 and that I met now or alive on Dec. 7, 1945

Immediate cause of death

Carcinoma of Stomach

DURATION

1 yr.

Due to

Due to

Other conditions none

(Include pregnancy within 3 months of death)

Major findings of operations Carcinoma of StomachDate of op. 6-27-45

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Geo. F. Buxton M.D.

M. D. or other

Address Elliott City Md. Date signed 12-8-45

CERTIFICATE OF DEATH

RECEIVED  
DEC 11 1945  
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

12419

Reg. Dist. No. 191

## 1. PLACE OF DEATH:

County HowardCity or town Ellicott City Rural  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County HowardCity or town Ellicott City Rural  
(If outside city or town limits, write RURAL and give nearest town)Street No. Carroll's Manor  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Elizabeth Hammond

## 3. (b) Social Security Number

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

F

C

Widow

6.(b) Name of husband or wife Richard Hammond

7. Birth date of deceased (mo., day, yr.) 6.(c) If alive, give age years

deceased (mo., day, yr.)

1875

8. AGE: Years Months Days If less than one day

70

hrs. min.

9. Birthplace Howard County Md  
(Town, county, and state)10. Usual occupation At home

11. Industry or business

FATHER 12. Name Unknown

13. Birthplace

MOTHER 14. Maiden name

15. Birthplace

16. Informant Joseph JonesAddress Ellicott City, Md.17. Burial Date thereof 12-15-45  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory St. LouisLocation Clarksville18. Funeral director F.C. HiginbothamAddress Ellicott City, Md.19. 12/15 19 45 John B. Loughan  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: December 13 19 45 at 6.30A M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9-14 19 45 to 12/13 19 45 and that I last saw her alive on 12/13 19 45

Immediate cause of death

Hypertensive Cardiovascular Disease

DURATION

1 year

Due to

Due to

Other conditions

Hemiplegia - stroke 4 months

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury injured at work?

23. SIGNATURE

George E. Broughton M.D. M.D. or other  
Address Ellicott City, Md. Date signed 12/14/45



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DEC 20 1945

BUREAU V S

3

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## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore *BD*

12420

## CERTIFICATE OF DEATH

Reg. Dist. No. *191*

## 1. PLACE OF DEATH:

County *Howard*City or town *Ellicott City, R. F. D.*  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? *82 yrs*

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State *Maryland* County *Howard*City or town *Ellicott City, R. F. D.*  
(If outside city or town limits, write RURAL and give nearest town)Street No. *Clarksville Pike*  
(If rural, give LOCATION)2.(a) If veteran, name war *None*

## 3. (a) FULL NAME

*Emma Virginia Harding*

## 3. (b) Social Security Number

*None*4. Sex *Female*5. Color or race *White*6.(a) Single, married, widowed, or divorced *Widowed*6.(b) Name of husband or wife *Wm. H. Harding*

6.(c) If alive, give age \_\_\_\_\_ years

7. Birth date of deceased (mo., day, yr.) *Feb. 1, 1863*

8. AGE: Years Months Days If less than one day

*82 10 6* hrs. min.9. Birthplace *Ellicott City, Howard Co., Md.*  
(Town, county, and state)10. Usual occupation *Housewife*

11. Industry or business

12. Name *James Oliver Jones*13. Birthplace *Unknown*14. Maiden name *Sarah Conner*15. Birthplace *Unknown*16. Informant *Alphens Harding*Address *Clarksville Pike*17. *Burial* Date thereof *Dec. 10, 1945*  
(Burial, cremation, or removal; Which?) (month) (day) (year)Cemetery or crematory *St. John's Cem.*Location *Ellicott City, Md.*18. Funeral director *Eaton Sons*Address *Ellicott City, Md.*19. *Dec. 10, 1945* John B. Lughan  
(Date rec'd by registrar) (Signature) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH *Dec. 7, 1945* at *2:10 P.M.*

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

*Jan 1945* to *Dec. 7, 1945*and that I last saw him/her alive on *Dec. 7, 1945*Immediate cause of death *Cerebral Hemorrhage*DURATION *4 days*Due to *Cardiovascular disease*Due to *Atherosclerosis*

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE *John B. Lughan, M.D.*Address *Ellicott City, Md.* M. D. or otherDate signed *12-9-45*

RECEIVED  
DEC 11 1945  
BUREAU V. &

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 29a

## CERTIFICATE OF DEATH

★ 12421 195  
Reg. Dist. No.

### 1. PLACE OF DEATH:

County Harward  
City or town High Ridge, Maryland  
(If outside city or town limits, write RURAL NEAR and give town)  
Street address, hospital, or institution: Harward P.O.

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 30 yrs

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Maryland County Harward  
City or town High Ridge Ward No.  
(If outside city or town limits, write RURAL NEAR and give town)

Street No. (If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

### 3. (a) FULL NAME

Lottie Boyer Hern

### 3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Married

8 (b) Name of husband or wife N. H. Hern

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 25, 1880

8. AGE: Years 65 Months 0 Days 12 hrs. min.

9. Birthplace Anne Arundel Co., Md.  
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

12. Name William F. Boyer

13. Birthplace Anne Arundel Co.

14. Maiden name Jamie Gardner

15. Birthplace Anne Arundel Co.

16. Informant N. H. Hern

Address High Ridge, Maryland

17. Burial Date thereof Dec. 10, 1945  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory My Hill Cemetery

Location Laurel, Maryland

18. Funeral director Mc Kith & Donaldson

Address Laurel, Maryland

19. 12/9 19 45 Dr. Frank Shipley  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH December ? 19 45 at 11 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 1 19 39 to Dec 7 19 45  
and that I last saw him alive on Dec 7 19 45

Immediate cause of death Cerebral hemorrhage

DURATION

10 yrs

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Robert S. McHenry, Jr.  
M. D. of other

Address Laurel, Md.

Date signed 12/7/45

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

DEC 15 1945

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 22

## CERTIFICATE OF DEATH

Reg. Dist. No. 12422 190

## 1. PLACE OF DEATH:

County HowardCity or town Elkridge  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 42 yrsHospital, institution, or street address where death occurred: Landing Rd

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County HowardCity or town Elkridge  
(If outside city or town limits, write RURAL and give nearest town)Street No. Landing Rd  
(If rural, give LOCATION)2. (a) If veteran, name war none

## 3. (a) FULL NAME

James William Elphart

## 3. (b) Social Security Number

none4. Sex Male5. Color or race White6. (a) Single, married, widowed, or divorced Widowed8. (b) Name of husband or wife Caroline AgnesHammer Elphart7. Birth date of deceased (mo., day, yr.) Apr 8 - 18558. AGE: Years 90 Months 8 Days 2 If less than one day

hrs. min.

9. Birthplace Elkridge, Howard Co. Md  
(Town, county, and state)10. Usual occupation Farmer11. Industry or business "12. Name William Elphart13. Birthplace Md14. Maiden name Elizabeth Mullman15. Birthplace Howard Co. Md16. Informant Charles W. ElphartAddress Elkridge, 2717. Burial Date thereof Dec. 13, 1945  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory St. Johns CemeteryLocation Edlicott City Md18. Funeral director Easton JonesAddress 608 Frederick Ave. Catonsville, Md19. Dec. 12, 45 (Date rec'd by registrar)20. Miss E. Bird Wilkins Registrar

## MEDICAL CERTIFICATION

2D. DATE OF DEATH Dec 10 19 45, at 10:30 M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 19 45, to Dec 10 19 45and that I last saw him alive on Dec 10 19 45Immediate cause of death Dr. Myocardialis Decompensation

DURATION

Due to General arteriosclerosisDue to Senility

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. B. Bunch

M. D. or other

Address 609 Main St. ElkridgeDate signed 12/10/45



RECEIVED  
DEC 14 1945  
BUREAU V.E.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for addition of place of death is shown on

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1628

12423 193  
Reg. Dist. No.

FILM No. 100 JAN 11 1946

## CERTIFICATE OF DEATH

### 1. PLACE OF DEATH:

County... Howard County  
City or town... Montgomery  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

### 3. (a) FULL NAME

Charles F. Pester

4. Sex

Male

5. Color or race

W

6. (a) Single, married, widowed, or divorced

Widow

6. (b) Name of husband or wife

Martha Pester

7. Birth date of deceased (mo., day, yr.)

May 1, 1858

6. (c) If alive, give age... years

8. AGE:

Years 87

Months 7

Days 26

If less than one day

hrs. min.

9. Birthplace

Montgomery Co. Md.  
(Town, county, and state)

10. Usual occupation

Lab.

11. Industry or business

Emory Pester

12. Name

Maryland

13. Birthplace

Shah Ward

14. Maiden name

Mrs. Emory Pester Burdette

15. Birthplace

Shoppersville Md.

16. Informant

Dr. Paul D. Barber

Address

Shoppersville Md.

17. Funeral director

Paul W. Barber

Address

Shoppersville Md.

18. (Date rec'd by registrar)

12/28/45

19. (Date rec'd by registrar)

12/26/45

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... Howard Co

City or town...  
(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

### 3. (b) Social Security Number

2

### MEDICAL CERTIFICATION

20. DATE OF DEATH... Dec 26 1945 at 2:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Mar 4 1930 to Dec 26 1945

and that I last saw him/her on Dec 20 1945

Immediate cause of death

General debility due to old age  
Heart just gave out from general debility

DURATION

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

C. M. Van Pelt

Address... Mt Airy Md Date signed 12/26/45

RECEIVED

JAN 7 1946

BUREAU V. R.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 932

## CERTIFICATE OF DEATH

Reg. Dist. No. 191

### 1. PLACE OF DEATH:

County Howard  
City or town Ellicott  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 74 yrs  
Hospital, institution, or street address where death occurred:  
How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Maryland County Howard  
City or town Ellicott  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. Clarksville Pike  
(If rural, give LOCATION)  
2.(a) If veteran, name war None

### 3. (a) FULL NAME

Annie C. Linthicum

### 3. (b) Social Security Number

None

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Single

6.(b) Name of husband or wife None

7. Birth date of deceased (mo., day, yr.) May 22, 1871

8. AGE: Years 74 Months 7 Days 1 It less than one day

9. Birthplace Ellicott Howard Co. Md.  
(Town, county, and state)

10. Usual occupation Household duties

11. Industry or business Own home

12. Name Andrew A. Linthicum

13. Birthplace Howard Co. Md.

14. Maiden name Francis R. Baither

15. Birthplace Howard Co. Md.

16. Informant Miss E. Elizabeth Linthicum

Address Ellicott, Md.

17. Burial (Burial, cremation, or removal, which?) Burial Date thereof Dec. 26, 1945  
(month) (day) (year)

Cemetery or crematory St. Johns Cemetery

Location Ellicott City, Md.

18. Funeral director Easton Sons

Address Ellicott City, Md.

19. Dec. 26, 1945 John B. Hughes  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 23, 1945 at 8 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 21, 1945 to Dec. 23, 1945

and that I last saw him alive on Dec. 23, 1945

Immediate cause of death Ac. Myocardial Failure DURATION 2 hrs

with Pulmonary edema

Due to Ch. Myocarditis - 4 yrs.

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Frank Shipley, M.D.

Savage, M.D. M. D. or other

Address 12/24/45 Date signed

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED  
JUN 27 1945  
BUREAU V &

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1702)

## CERTIFICATE OF DEATH

12425

Reg. Dist. No. ....

## 1. PLACE OF DEATH:

County HowardCity or town Savage, Balto. Wash. Blvd.  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 45 Min.

Hospital, institution, or street address where death occurred:

Rt. # 1 Savage, Md.How long in hospital or institution? None

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montg.City or town Kensington, Md.  
(If outside city or town limits, write RURAL and give nearest town)Street No. 57 Kensington Parkway  
(If rural, give LOCATION)

2. (a) If veteran, name war .....

## 3. (a) FULL NAME

William F. Mathews

## 3. (b) Social Security Number

## 4. Sex

Male

## 5. Color or race

W

## 6. (a) Single, married, widowed, or divorced

No6. (b) Name of husband or wife Unknown

6. (c) If alive, give age ..... years

## 7. Birth date of

deceased (mo., day, yr.) 20 February 1924

## 8. AGE:

Years

Months

Days

If less than one day

21104

..... hrs.

..... min.

## 9. Birthplace

Unknown

(Town, county, and state)

## 10. Usual occupation

Soldier

## 11. Industry or business

U. S. Army

## FATHER

## 12. Name

Unknown

## 13. Birthplace

Unknown

## MOTHER

## 14. Maiden name

Unknown

## 15. Birthplace

Unknown

## 16. Informant

Address

17. Removal  
(Burial, cremation, or removal. Which?)RemovalDate thereof 12/24/45  
(month) (day) (year)

## Cemetery or crematory

Spokane Funeral Home

## Location

13th & N. Sts. N.W. Washington, D.C.

## 18. Funeral director

Address

Howard H. Blight Jr.  
4914 Belair Road

## 19.

24 December19 45

(Date rec'd by registrar)

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 12/24 19 45 at 1:15 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

12/24 19 45 to 12/24 19 45and that I last saw h. no date alive on ..... 19 .....

Immediate cause of death

broken neck

DURATION

instantDue to Traumatic rupture of right ventricleof heart. C.R.

Due to .....

Other conditions 3 fractured ribs on rt. instant

(Include pregnancy within 3 months of death)

Major findings of operations

none

Date of op. ....

Autopsy results

none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide accident Date of 12/23/45Where did injury occur? new Savage Howard Md.  
(City or town) (County) (State)Injured at home, farm, industry, public place (where?) Highway Route #1Means of injury Auto Collision Injured at work? no

23. SIGNATURE

George E. Buntorf M.D.

DEPUTY MEDICAL EXAMINER OF HOWARD COUNTY, M. D. or other

Address Ellen City, Md. Date signed 12/24/45



RECEIVED  
DEC 27 1945  
BUREAU V. A.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

## 1. PLACE OF DEATH:

County... HOWARDCity or town... NEAR ELLICOTT CITY  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? TWO DAYS

Hospital, institution, or street address where death occurred:

PINEL CLINIC - HOWARD COUNTYHow long in hospital or institution? TWO DAYS

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... MARYLAND County... BALTIMORE CITYCity or town... BALTIMORE CITY  
(If outside city or town limits, write RURAL and give nearest town)Street No. 5 W FRANKLIN STREET  
(If rural, give LOCATION)2.(a) If veteran, name war WORLD WAR 1917/1918 ✓

## 3. (a) FULL NAME

FREDERICK HARDING SHEPHERD

## 3. (b) Social Security Number

4. Sex

MALE

5. Color or race

WHITE

6.(a) Single, married, widowed, or divorced

DIVORCED

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) DECEMBER 17 18928. AGE: Years Months Days If less than one day  
52 52 11 17 ..... hrs. .... min.9. Birthplace Mc MINNVILLE TENNESSEE  
(Town, county, and estate)10. Usual occupation... PRINTER

11. Industry or business

12. Name THOMAS SHEPHERD13. Birthplace ROANOKE - VIRGINIA14. Maiden name... LURAH WADE15. Birthplace TENNESSEE16. Informant CAROLINE DIGGSAddress MARINE HOSPITAL BALTO WYMAN PK17. Buried Date thereof Dec 8 1945  
(Burial, cremation, or removal Which?) (month) (day) (year)Cemetery or crematory Ardenwood BaptistLocation Ardenwood Baptist18. Funeral director John F. Small Funeral HomeAddress 4644 YORK AVE. B.D.19. 2/7 19 45 Register  
(Date read by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH DECEMBER 4<sup>th</sup> 19 45 at 10<sup>15</sup> A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from DECEMBER 3<sup>rd</sup> 19 45 to DECEMBER 4<sup>th</sup> 19 45 and that I last saw him alive on DECEMBER 4<sup>th</sup> 19 45Immediate cause of death CEREBRAL HEMORRHAGE DURATION 5 HOURS

Due to.....

Due to.....

Other conditions CHRONIC ALCOHOLISM

(Include pregnancy within 3 months of death)

Major findings of operations.....

..... Date of op. ....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Helmuth Prager M.D.Address ELLICOTT CITY M.D. Date signed 12/4/1945

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (6)

## CERTIFICATE OF DEATH

12427

Reg. Dist. No. 191

## 1. PLACE OF DEATH:

County.....

City or town.....ELLICOTT CITY  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

Hospital, institution, or street address where death occurred:

How long in hospital or institution?.....

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....Md. County.....HOWARDCity or town.....ELLICOTT CITY  
(If outside city or town limits, write RURAL and give nearest town)Street No.....FOLLY QUARTER  
(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3.(a) FULL NAME

REV. PATRYK TOPOLSKI O.F.M.C.

## 3.(b) Social Security Number

## 4. Sex

MALE

## 5. Color or race

WHITE

## 6.(a) Single, married, widowed, or divorced

CATHOLIC PRIEST

## 6.(b) Name of husband or wife.....

## 7. Birth date of

deceased (mo., day, yr.)

MAY 3rd 1872

## 8.(c) If alive, give age..... years

## 8. AGE:

Years

Months

Days

If less than one day

73

hrs.

min.

## 9. Birthplace.....

Poland

(Town, county, and state)

## 10. Usual occupation.....

CATHOLIC PRIEST

## 11. Industry or business

FATHER

## 12. Name.....

unknown

## 13. Birthplace.....

unknown

MOTHER

## 14. Maiden name.....

unknown

## 15. Birthplace.....

unknown

## 16. Informant.....

REV. DAMIAN WYDRO

## Address.....

ELLICOTT CITY, MD

## 17. ENTOMBMENT

(Burial, cremation, or removal. Which?)

Date thereof.....12-13-45  
(month) (day) (year)

## Cemetery or crematory.....

ST. STANISLAUS

## Location.....

BALTIMORE MD

## 18. Funeral director.....

George A. Weber

## Address.....

705 So Ann St

## 19.

(Date registered by registrar)

12/10

19

45 A.W. Hedrick

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH.....Dec 8 1945 at 6:30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Sept. 1942 to Dec 8 1945and that I last saw him.....Dec 7 1945

Immediate cause of death.....

Coronary Heart Disease

DURATION

acute

Due to.....

Diabetes Mellitus7

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?.....

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?).....

Means of injury.....

Injured at work?.....

23. SIGNATURE.....

John G. Korman M.D.

M. D. or other

Address.....

Ellicott City MdDate signed.....12/8/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 932

## CERTIFICATE OF DEATH

Reg. Dist. No. 171.192

## 1. PLACE OF DEATH:

County HowardCity or town Maryrosettville  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County HowardCity or town Maryrosettville  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Blanche Wherrett

## 3. (b) Social Security Number

None

## 4. Sex

F

## 5. Color or race

W

## 6. (a) Single, married, widowed, or divorced

Single

## 6. (b) Name of husband or wife

6. (c) If alive, give age \_\_\_\_\_ years

## 7. Birth date of

deceased (mo., day, yr.)

June 10, 1872

## 8. AGE:

Years

Months

Days

If less than one day

73526

hrs.

min.

## 9. Birthplace

Cummersville, Ind.  
(Town, county, and state)

## 10. Usual occupation

Retired

## 11. Industry or business

FATHER

## 12. Name

Wm. Henry Wherrett

## 13. Birthplace

Indianapolis

MOTHER

## 14. Maiden name

Bea Jane Pratt

## 15. Birthplace

Kentucky

## 16. Informant

Mrs. Ruth Bowen

## Address

Maryrosettville, Md.17. Cremation

(Burial, cremation, or removal. Which?)

Date thereof Dec. 7, 1945  
(month) (day) (year)

## Cemetery or crematory

Lawson Park

## Location

Baltimore, Md.

## 18. Funeral director

F.C. Higginbottom

## Address

Elmatt City, Md.19. Dec. 7

(Date rec'd by registrar)

1945John B. Laughman  
Reg. No. G. 2. 1

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 6 1945 at 6:2 M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

Oct 1 1945 to Dec. 6 1945and that I last saw him alive on Dec. 5 1945

Immediate cause of death

Hypertensive heart disease

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

John Q. Korman, M.D.

M. D. or other

Address Elmatt City, Md. Date signed 12/6/45

RECEIVED

JAN 25 1946

BUREAU V.S.